Prior Authorization of Power Mobility Devices (PMD) Demonstration

Supplier/ Physician Outreach and Education

Updated March 13, 2012

Definition of PMD

Included	
All Power Operated Vehicles	K0800 – K0805 K0809 – K0812
All standard power wheelchairs	K0813 – K0829
All Group 2 complex rehabilitative power wheelchairs	K0835 – K0843
All Group 3 complex rehabilitative power wheelchairs without power options	K0848 – K0855
All pediatric power wheelchairs	K0890 – K0891
Miscellaneous power wheelchairs	K0898
Excluded	
Group 3 complex rehabilitative power wheelchairs with power options	K0856 – K0864

Same Coverage Requirements as Today

- The Prior Authorization demonstration:
  - Does not create new documentation requirements for practitioners and suppliers.
  - It simply requires the information be submitted earlier in the claims process.
  - All Advanced Beneficiary Notice (ABN) procedures remain unchanged.
  - Current requirements can be found on the MAC website.

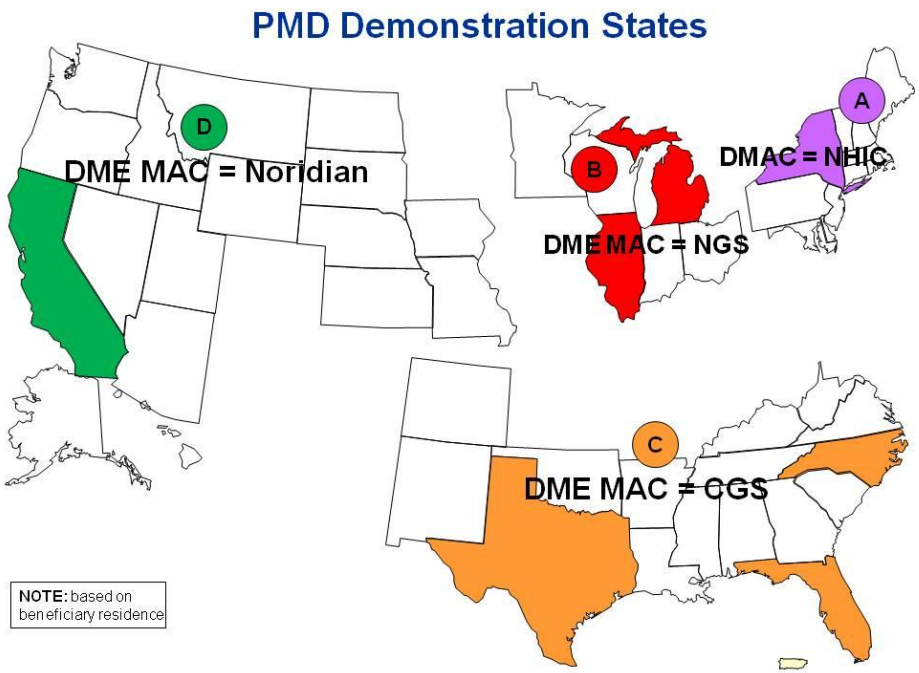
When

- Federal Register Notice on or about May 2012 announcing actual start date of demonstration.

- CMS expects
  - The demonstration will begin for orders written on or after June 1, 2012
  - All states will start at approximately the same time.
  - Continuous Education of supplier, physicians/ practitioners and beneficiaries.
  - Demonstration ends 3 years later in all 7 States.

Where

- Beneficiaries residing in 7 error prone and fraud prone states: CA, IL, MI, NY, FL, NC and TX (based on address reported to the Social Security Administration):
  - These 7 states account for $262M of the roughly $606 M spent annually on PMDs.
    - That is 43% of total expenditures.



Why

- Developing improved methods for the investigation and prosecution of fraud
  - Based on previous experience there is extensive evidence of DME fraud committed in these states.
- Focuses **on error-prone claim type.**
  - Error rate for PMD: over 80%*.
- Uses **private sector methodology** to protect the Medicare Trust Funds.
- Reduces pay and chase syndrome by **stopping improper payments** before they are made.

* According to the HHS OIG Spotlight On… Power Wheelchair (http://oig.hhs.gov/newsroom/news-releases/2011/wheelchair-medicare.asp)

CMS Adopts Changes in Response to Industry Feedback

- This demonstration was originally announced on November 15, 2011.

- CMS published a Paperwork Reduction Act (PRA) Package addressing both continued general medical review and the demonstration in December 2011.
  - CMS received a number of comments about this demonstration with the December 2011 PRA package.

CMS Adopts Changes in Response to Industry Feedback

Concern	Revised Demonstration Process
Supplier maybe financially impacted by the 100 percent prepayment review phase of the demonstration.	The Demonstration has eliminated prepayment review (formerly Phase 1) and will go straight to Prior Authorization.
The ordering physician may not be in the best position to submit the prior authorization request.	The physician/ treating practitioner **or** supplier on behalf of the physician/ treating practitioner may perform the administrative function of submitting the Prior Authorization request.
Some states will be under 100 percent prepayment review while other states are using prior authorization.	All demonstration states will start prior authorization at approximately the same time.
There was limited notice given prior to the proposed start date.	•CMS has delayed the implementation until on or after June 1, 2012. •CMS has submitted a separate PRA package. This will allow providers and supplier at least 60 days to comment on the collection of information burden of the demonstration. •CMS plans a Federal Register Notice announcing the start date. •CMS will send certified letters to suppliers and practitioners in the demonstration states.

Prior Authorization

- LCD requirements mandating physician/ treating practitioner must be completed by the physician/ treating practitioner.

- The supplier will still complete the detailed product description regardless of which entity is functioning as the submitter.

- Ordering physician/practitioner **or** supplier performs the administrative function of submitting a prior authorization request to the DME MAC:
  - Progress notes documenting the face-to-face exam,
  - 7 element order, detailed product description
  - Other medical documentation

Prior Authorization

- The DME MAC will review request and postmark notification of a written decision within 10 days to:
  - Physician/practitioner
  - Beneficiary
  - Supplier

- Within 10 days, the DME MAC will either
  - Affirm the prior authorization request
  - Not affirm the prior authorization request
    - Provide a detailed written explanation outlining which specific policy requirement(s) was/were not met.

Prior Authorization

- Submitter may re-submit (**unlimited requests** are allowed)
  - DME MAC will review SUBSEQUENT requests within **30 days**.

- Suppliers should receive a Prior Authorization request decision from the DME MAC **before** the supplier delivers the item and submits the initial claim.

Prior Authorization

- In rare circumstances a 48 hour expedited review for emergencies.
  - In a situation where a practitioner indicates clearly with rationale that the standard (routine) timeframe for a Prior Authorization Decision (10 days) could seriously jeopardize the beneficiary's life or health, the contractor will conduct an expedited review.
  - The expedited request must be accompanied by the required supporting documentation for this request to be considered complete thus engaging the 48 hours for review.
  - Inappropriate expedited requests may be downgraded to standard requests.

Potential Issues with a Request

Problem	Solution
Order written before Face-to-Face Exam	• Write new order. • Submit new request.
More than 45 days between Face-to-Face exam and written order.	• Conduct a new Face-to-Face exam, • Write a new order. • Submit a new request.
Element on order missing	• Write a new order that contains all 7 elements. •Submit new request.
Coverage criteria not met (the detailed review requests will specify which criteria were not met).	• Remember that DME is covered by Medicare only for use in the home. • Review the documentation sent with the prior authorization request, consider sending more documentation. • If insufficient documentation exists, re-evaluate the beneficiary and document the missing information. • Conduct new Face-to-Face exam. • Submit new request.
Incomplete Face-to-Face Exam	• Must document an in-person visit for the purpose of documenting the need for a PMD (does not have to be primary). • Perform medical evaluation.

Resubmission and Appeals

- Prior Authorization:
  - For non-affirmed Prior Authorization requests, unlimited resubmissions are allowed.
  - For denied claims, all current appeal rights apply.

Scenarios

A prior authorization request is	The DME MAC decision is to	The supplier chooses to	The DME MAC will
Submitted	Affirmative	Submit a claim	Pay the claim (as long as all other requirements are met).
Submitted	Non-affirmative	Submit a claim	Deny the claim.
Not submitted	N/A	Submit a claim **(Competitive Bid Supplier)**	**Develop the claim.** Review the claim. If payable, pay at normal rate.
Not submitted	N/A	Submits a claim **(Non-Competitive Bid Supplier)**	**Develop the claim.** Review the claim. If payable, pay at 75% of Medicare payment.*

* Applies only to codes in the demonstration, not accessories and **starts 3 months after the demonstration begins.**

Physician Reimbursement

- Physician/Practitioner can bill G9156 after he/she submits an initial Prior Authorization Request.
  - G-code is billed to the A/B MAC contractors with the Prior Authorization tracking number.
  - Only one G-code may be billed per beneficiary per PMD even if the physician/ practitioners must resubmit the request.
  - Code is not subject to co-insurance and deductible.

- This partially compensates **physician/ practitioner** for the additional time spent if he/she is the entity submitting a Prior Authorization request.

Beneficiary Impact

- The PMD benefit is not changing.
- Beneficiaries will receive a notification of the decision about their prior authorization request.
- CMS encourages beneficiaries to use suppliers who accept assignment.

The Face-to-Face Examination

- State that the purpose of the face-to-face was to discuss the need for a PMD.
- History of present condition and relevant past medical history, including:
  - ✓ Symptoms that limit ambulation,
  - ✓ Diagnoses that are responsible for symptoms,
  - ✓ Medications or other treatment for symptoms,
  - ✓ Progression of ambulation difficulty over time,
  - ✓ Other diagnoses that may relate to ambulatory problems,
  - ✓ Distance patient can walk without stopping,
  - ✓ Pace of ambulation,
  - ✓ Ambulatory assistance currently used,
  - ✓ Change in condition that now requires a PMD; and
  - ✓ Description of home setting and ability to perform ADLs in the home.

- Physical examination relevant to mobility needs, including:
  - ✓ Height and weight,
  - ✓ Cardiopulmonary examination; and
  - ✓ Arm and leg strength and range of motion.

- Neurological examination, including:
  - ✓ Gait, and
  - ✓ Balance and coordination.

NOTE: Not all elements listed apply to every patient. Professional discretion is necessary to determine which items are required as part of the face-to-face examination.

The Valid 7-Element Written Order

1. Patient name

2. Description of item ordered
   - "Power operated vehicle"
   - "Power wheelchair",
   - "Power mobility device"
   - Or something more specific

3. Date of face-to-face examination

4. Diagnoses/conditions related to need for PMD

5. Length of need

6. Physician/practitioner signature

7. Date of physician/practitioner signature.

Detailed Product Description

- The detailed product description must be completed by the supplier, and reviewed and signed by the treating physician. It must contain:
  - ✓ Specific Healthcare Common Procedure Coding System (HCPCS) code for base and all options and accessories that will be separately billed;
  - ✓ Narrative description of the items;
  - ✓ Manufacturer name and model name/number;
  - ✓ Physician signature and date signed; and
  - ✓ Date stamp to document receipt date.

Summary

Where	Beneficiaries in CA, Il, MI, NY, NC, Fl, TX
The demonstration will begin for:	Orders for PMD written on **or** after June 1, 2012
Submitted by	Physician/ Practitioner **or** supplier on behalf of Physician/ Practitioner
Ends	About May 31, 2015 (3 years after start date).

For More Information

Email the Prior Authorization Team	Pademo@cms.hhs.gov
CMS Demonstration Website	go.cms.gov/PAdemo
FAQs	https://questions.cms.hhs.gov/app/home keyword: PMD
Follow Us on Twitter	@CMSGov (Look for #pmd_demonstration)
To receive Broadcast Emails	Details coming soon

References on PMDs from the MACs

- Jurisdiction A: NHIC, Corp.

http://www.medicarenhic.com/dme

- Jurisdiction B: National Government Services (NGS)

http://www.ngsmedicare.com/wps/portal/ngsmedicare/home

- Juridiction C: CGS

http://www.cgsmedicare.com/jc

- Jurisdiction D:Noridian Administrative Services, LLC (NAS)

https://www.noridianmedicare.com/dme

FAQs

Questions From the Audience